MEDICAL HISTORY FORM

NAME:_____ **AGE:**_____

OCCUPATION:_____ **HEIGHT:**_____ **WEIGHT:**_____ **DOB:**_____

☐ **Right Handed** ☐ **Left Handed** **PREFERRED PHARMACY:**_____ **PHARMACY PHONE:**_____

ALLERGIES (Drug/Food/Latex/Metal):_____

_____

CURRENT MEDICATIONS INCLUDING HERBAL SUPPLEMENTS/ DOSAGE: _____

_____

MEDICAL HISTORY

Have you had any of these problems?:

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Clots (DVT)
- ☐ Blood Clot in Lung (Pulmonary Embolism)
- ☐ Bone Infection
- ☐ Cancer: _____
- ☐ Carpal Tunnerl Syndrome
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Cushing's Syndrome
- ☐ Dental Cavities/ Periodontal Disease
- ☐ Problems with Anesthesia
- ☐ Depression
- ☐ Diabetes
- ☐ Dislocated Joint: _____
- ☐ Fibromyalgia
- ☐ Fractured Bone: _____
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis: _____
- ☐ Herniated Disc
- ☐ Hiatal Hernia
- ☐ History of MRSA or other skin/joint infection
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Neck Injury
- ☐ Osteoarthritis
- ☐ Osetoporosis
- ☐ Paralysis-partial or complete
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Sleep Apnea
- ☐ Neck Radiataion
- ☐ Reflux
- ☐ Renal Failure/Dialysis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Scoliosis (Curved Spine)
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer Disease
- ☐ Rheumatic Fever
- ☐ Vision or hearing abnormalities
- ☐ Other: _____ _____

SURGICAL HISTORY

Have you ever had an operation to the following areas?: If so, please specify with approximate dates

- ☐ No history of surgery
- ☐ Abdomen: _____
- ☐ Back/Neck: _____
- ☐ Cancer: _____
- ☐ Extremity: _____
- ☐ Fracture: _____
- ☐ Hysterectomy: _____
- ☐ Kidney: _____
- ☐ Lung: _____
- ☐ Open Heart Surgery: _____
- ☐ Pacemaker Insertion: _____
- ☐ Defibrillator Insertion: _____
- ☐ Stent Insertion: _____
- ☐ Other: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: **If YES, who?:**

- ☐ Arthritis: _____
- ☐ Cancer: _____
- ☐ Diabetes: _____
- ☐ Heart Disease: _____
- ☐ High Blood Pressure: _____
- ☐ Osteoporosis: _____
- ☐ Problems with anesthesia: _____
- ☐ Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT): _____
- ☐ Other: _____

SOCIAL HISTORY

DO YOU:

Consume Alcoholic Beverages:	____YES	____NO	If yes, how much/often:_____
Consume Tobacco Products:	____YES	____NO	If yes, how much/often:_____
Are you a past smoker:	____YES	____NO	If yes, how long ago did you quit?:_____

PATIENT SIGNATURE: _____ **DATE:** _____

Entered by: _____ Date: _____ Reviewed by: _____ Date: _____